Livewell Southwest

Mental Health Matters Helpline Protocol

Version No.1

Notice to staff using a paper copy of this guidance

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Asset Number: **883**

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Version no.	Type of change	Date	Originator of change	Description of change
0.1	New Protocol	December 2014	Deputy Locality Manager	New Protocol
1	Ratified	May 2015	Policy Ratification Group	Ratified.

Mental Health Matters Helpline Protocol

1 Introduction

1.1 In September 2013 Livewell Southwest commissioned an Out of Hours Mental Health / Emotional telephone support helpline. This helpline is run by an organisation known as Mental Health Matters. Website address - http://www.mentalhealthmatters.com/ The service is based in the North East of the UK and is staffed by qualified counsellors. The commissioned hours of operation are from 5pm-9am Monday to Friday and 24 hours a day over weekends and bank holidays.

1.2 This service is only for people who are in receipt of secondary mental health services.

2 Purpose

2 The purpose of this policy is to describe and define the remit of the Mental Health Matters Helpline.

3 Definitions

3.1 **MHM** – Mental Health Matters – a company based in the North East that is commissioned by Livewell Southwest (LSW) to provide out of hours mental health telephone support to Plymouth patients.

Out of hours – all times that are outside of normal office working hours – specifically 5pm-9am Monday to Friday and 24 hours a day over Weekends and Bank holidays.

Home Treatment Team (HTT) – a service providing 24 hour support to patients who would otherwise be in hospital. The team also provide a link to mental health services for the MHM helpline.

CMHT – Community Mental Health Teams

AOS – Assertive Outreach Service

ASR – Asylum Seekers and Refugee Service

CFT – Community Forensic Team

CNT – Complex Needs Team

CLDT – Community Learning Disability Team

OPMH – Older People's mental Health Service

111- a non-urgent health enquiry telephone helpline that seeks to redirect callers to the most appropriate service based on the caller's need.

Livewell Southwest – (LSW) – provider of NHS mental health services in Plymouth.

4 Duties & Responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all policies,

implementation and review.

4.2 Responsibilities of **Locality Managers – to** ensure that all teams adhere to this protocol.

4.3 Responsibility of **named LSW link manager with MHM, currently Deputy Locality Manager of Citywide Services** to maintain active monthly links with MHM to ensure excellent communication and standards are met and that this policy is adhered to.

4.4 Responsibility of all **staff** – to provide the MHM number to those people able to use the service and to ensure that service users are familiar with the purpose of MHM. To adhere to the terms of this protocol.

5 Description of the Service

5.1 Livewell Southwest recognises that people experience mental health issues over the 24 hour period and may require access to emotional support during the out of hours period when most mainstream services are not operating. Livewell Southwest is committed to providing mental health service users of Plymouth with high quality out of hour's emotional support. In addition to this, where necessary, Mental Health Matters will invoke their crisis pathway (see Appendix D & E) if a call requires it.

5.2 LSW has chosen Provision of a telephone helpline as a way of delivering this support. The helpline is remotely situated and is staffed by counsellors.

5.3 **Inclusion criteria**

Service users open to secondary mental health services including CMHT, AOS, ASR, CFT,OPMH, CLDT, CNT (see glossary above).

Exclusion criteria

- Service users open to Options only.
- GP held patients.
- University Students without an episode of care with secondary mental health services.
- Patients waiting for assessment with the CMHT or Options – should be supplied with the relevant CMHT duty number and 111 for out of hours.
- Young people attending the Zone unless on the caseload of secondary mental health services.
- Icebreak and Insight patients (they have an on-call service).
- Home Treatment Team patients – as HTT is available 24 hours a day.
- Service users assessed and not taken on by mental health services.
- Service users only open to Harbour or other specialist services.

The 111 national NHS helpline is available for people who are unable to use the MHM helpline. 111 is a 24/7 service.

5.4 The helpline is confidential and callers are encouraged to self-manage their use of the service. MHM record calls made to their service, unless a service user opts out of this at the start of a contact with MHM.

5.5 MHM does not make planned calls to service users.

5.6 Where required MHM are able to make professional referrals to mental health services in Plymouth – as this is an out of hours service, it has been determined that the Home Treatment Team is the most appropriate service to receive those referrals for patient aged between 18 and 65 years old. For service users aged over 65 years old MHM can refer a service user to local social services on 01752 668000, refer to Devon Docs or refer the person to the local Emergency Department.

5.7 When required MHM will invoke their crisis pathway which may involve calling emergency services to respond to a caller's need.

6 Reporting Mechanisms between LSW and MHM

6.1 There is a biannual telephone conference with the relevant LSW Locality Manager, LSW service manager and MHM director.

6.2 MHM sends a monthly report to the LSW service manager. This includes demographic details about callers, the number of calls received and answered, the number of callers leaving voicemails, the number of successful call-backs from voicemails, the type of problem that was discussed and the outcome of the call. In the last few months MHM have also started to include some qualitative data regarding how useful callers have found the service.

6.3 A telephone conference is held on a monthly basis between the MHM helpline manager and the designated LSW Manager. This telephone conference takes place shortly after the monthly report has been compiled and serves as a means to review use of the helpline. This monthly review has also enabled any issues to be discussed and resolved – e.g. initially MHM had not understood that they were able to make a professional referral to the HTT.

6.4 Complaints and compliments – where a complaint or concern is raised this is primarily managed through the LSW complaints procedure. The complaint is logged and the relevant LSW manager contacted by the customer service department. The LSW manager then brings the complaint to the attention of the MHM manager who investigates and feeds back to LSW. Where a caller has not opted out of a call being recorded, and where the date of a disputed call is available along with an identifiable telephone number MHM are able to review the exact call to provide feedback about complaints. In the absence of being able to locate a call MHM will make every attempt to speak to helpline operators who were working at the approximate time of the call to seek information and clarification about any complaints or concerns raised.

MHM seeks to gain some feedback from callers during their call to establish how

helpful the service has been. LSW has developed a service user questionnaire on Meridian.

7 Training Implications

7.1 There are no specific training implications identified in the function of the MHM helpline. Care coordinators are encouraged to ensure that crisis and contingency plans include MHM as part of the plan and not as the only plan.

8 Monitoring Compliance and Effectiveness

8.1 MHM provide a detailed report to LSW on a monthly basis. The content of the report covers – total number of calls per month, times calls are received, the kind of difficulty discussed and the outcome of the call, where possible the age range of the callers is also gathered.

8.2 LSW has implemented an MHM review committee that meets every quarter to review MHM. This committee is composed of Service Users, Carers, CMHT representatives, Clinical Governance, Commissioners, the relevant LSW manager, Home Treatment and inpatient services.

8.3 A Meridian Patient Survey is being used to obtain first hand feedback on the experience of using the MHM helpline. This questionnaire is carried out 6 monthly. Action plans will be developed in line with any areas that require improvement.

8.4 The relevant LSW Manager provides feedback to the Safety and Quality Committee on a quarterly basis.

8.5 LSW and MHM conduct a yearly contract process in line with the fiscal year.

9. Troubleshooting

9.1 Occasionally there have been difficulties in accessing the MHM helpline. On these occasions the on-call director has been supplied with a backdoor number to MHM to report difficulties so that MHM can solve these. Any staff member, including but not exclusively the Glenbourne Unit Coordinator, HTT Staff, Psychiatric Liaison and on-call manager, who become aware that there is an inability to contact MHM during the out of hour's period should contact the on-call director via Switchboard. The backdoor number is only accessible by the on-call director. The on-call director will be responsible for contacting MHM to resolve the service issue.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 7th December 2015

Appendix A

General Information about Mental Health Matters

The MHM Helpline is a “Remote-Access” support service for those with Mental Health Needs. It is built around a 24/7 telephone service, which is staffed by well trained and experienced staff. All staff recruited into the Helpline are required to have a certificate in Counselling and/or equivalent experience in the mental health field. Following appointment MHM staff receive further training.

The Helpline has been accredited by the Telephone Helplines Association (THA) against 12 national quality standards, and MHM continue to look for ways to improve the quality of the service that is provided.

In addition to the telephone service, there is also an on-line “live chat” where individuals can speak to a member of staff virtually. MHM also communicate with people through SMS text and email. The essence of our service is to enable people with Mental Health needs and who may be vulnerable to be able to speak to us at a time and in a way that suits their needs.

The Helpline service can encompass a number of different types of services, and can support individuals who are experiencing a wide range of different mental health needs, including for example:

- Phobias
- Schizophrenia
- Psychosis
- Suicidal thoughts
- Personality Disorder
- Depression
- Anxiety and stress related difficulties

There is a robust risk management policy and procedure that responds appropriately to assess and manage all levels of risk.

The Helpline is able to offer a range of services, such as:

1. Crisis Support: MHM are able to support individuals in Crisis, often de-escalating the situation without the need to engage with another service (e.g. Crisis Team).

2. Emotional Support: Often individuals need someone to talk to, and in the absence of any other source of support will utilise local emergency services and/or local health professionals. The Helpline can alleviate these pressures by being available for people to phone at any time. Calls are usually up to 20 minutes, but in reality sometimes people need longer than that which we are happy to support. As MHM workers have a range of training and experience they can adopt techniques such as CBT within calls to help support people when necessary.

Telephone Crisis Model

In September 2012 the Care Quality Commission published the results of a survey of over 15,000 people using Community Mental Health services. In this they reported that 60% of

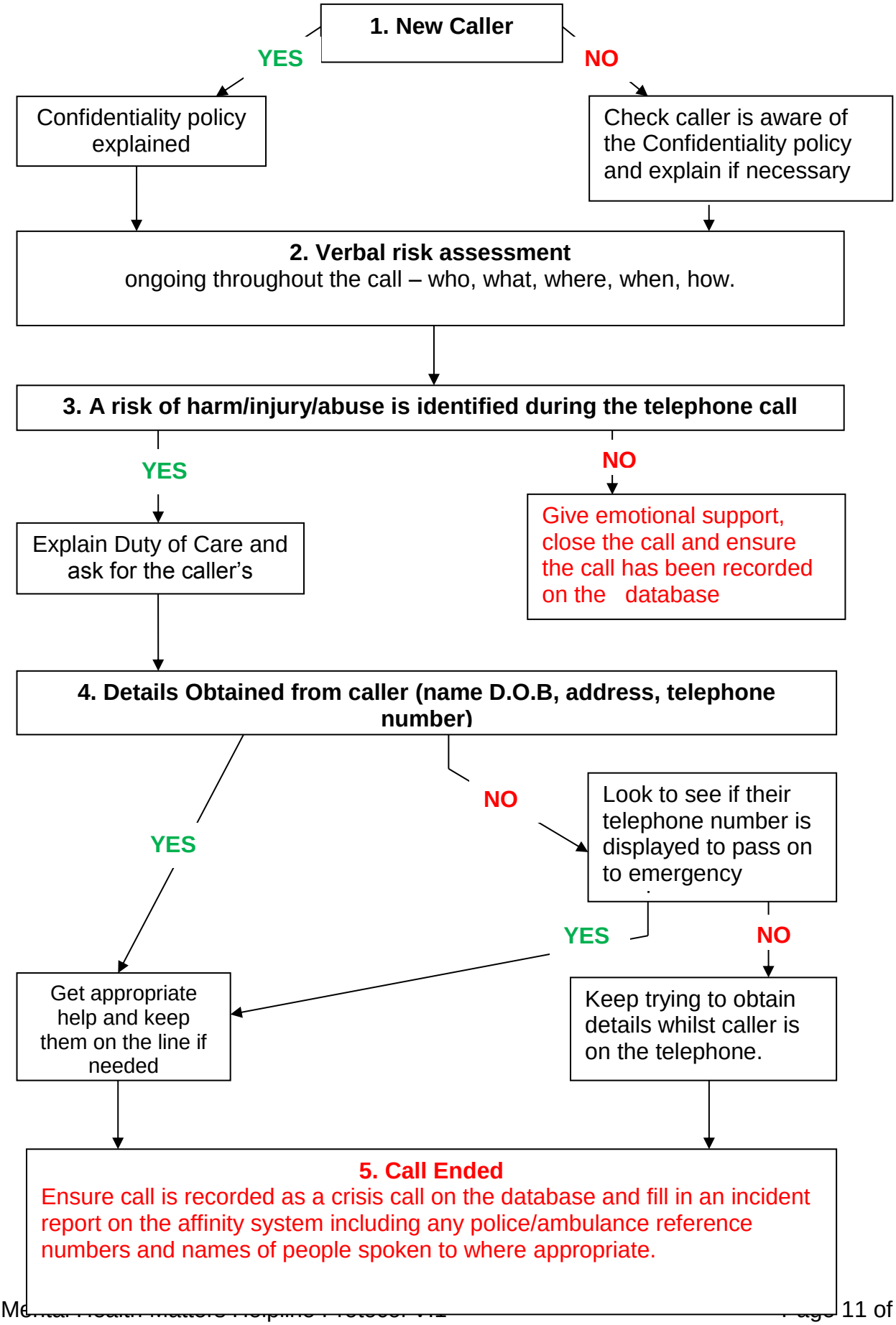
people in Crisis had the number of someone to call. Of that 60%, half stated they definitely received the help they needed.

This means that of all of the people in Crisis, less than a third felt confident that they had received the help they needed. There may be various reasons for this, including workloads, the receipt of inappropriate referrals, and a host of other issues, but it is clear from the CQC data that Crisis interventions still require additional support. The Helpline can support service providers to do so.

The 24/7 Crisis Model has been successfully operational for several years, and can be adapted to the needs of the local area. In this model, the Helpline service works in conjunction with mental health Crisis teams, providing a front-line service. All calls are routed to a MHM Helpline support worker where the assessment process begins. The support worker will explore the caller's issues to determine the next step, which will fall into either:

1. Non-crisis pathway
2. Crisis pathway

Appendix B **Helpline Call Flow Chart**



Appendix C
Helpline Call Protocol

On answering a telephone call please follow the following protocol;

1.New Caller- ascertain whether the caller is a new caller or not by asking them. If they are a new caller inform them of the confidentiality policy by reading the following statement;

"Everything we discuss will be kept confidential within the service unless there are any risks to yourself or others in which case I may have to involve other agencies and pass that on, is that ok?".

If they have called before check that they know about the confidentiality policy and remind them if necessary.

2. Verbal risk assessment

This is ongoing throughout the call and in response to the things discussed within the call. Use of open questioning is used to determine this using the following who, what where, when format;

2.1). **Who** is potentially at risk? Think also about who can help to manage these risks.

2.2). **What** are the potential risks? Think about the intent, past history, plans and preparations.

2.3). **Where** is the risk most likely to be highest? Think about physical environment.

2. 4). **When** is the risk most likely to be highest? Think about the situation when this is most likely to occur.

2.5). **How** does the risk situation come about? Think about triggers.

3. A risk of harm/injury/abuse is identified to the caller or others during the telephone call.

3.1). Physical emergency

- **Ambulance service**- When actual physical harm has already occurred and If the risk is a medical emergency. For example, overdose or physical injury.
- **Police-** When there is an immediate potential risk of physical harm and if the risk is a danger to themselves or others. For example, standing at the top of a motorway bridge by a railway track and threatening to jump.

3.2). Non- Physical emergency

- **The Crisis Team –** When the person is not an immediate risk to themselves or others but they are in a mental health crisis. For example feeling that they cannot cope or experiencing extreme symptoms of mental illness. The crisis team provide a rapid assessment for those people who are experiencing a mental health crisis of

such severity that without the intervention of the team, a hospital admission would be required. However, if there is an immediate risk of harm to the person or others the emergency services should always be contacted instead.

- **EDT (Emergency Duty Team, Social Services) –** Where there is abuse, either physical, mental/emotional, financial, sexual, neglect or a combination of these. The Emergency Duty Team provides an emergency social work service including at night, at weekends and bank holidays. They deal with Concern about a child or adult including , acute mental health problems, older people at risk, concerns about a person with a disability and emergency housing advice for vulnerable people.

3.3). Risk management

If there is a risk identified *ALWAYS* act on the information you are given. Ask yourself how can these risks be minimised or eliminated while you can get help. Think about what protective factors to include in your risk management discussion and explain the duty of care and that the information would need to be passed on and then try to obtain the caller's details. (See 4. Callers details).

4. Caller's Details

The details you are trying to obtain are as below and in order of priority;

- Address
- Telephone number
- Full name
- Date of birth
- If applicable- any substances/medication taken including quantity or strength
- If applicable – details of mental health/physical condition(s)
- If applicable – any details of possible risk to emergency services such as weapons
- If applicable – names and dates of birth of others at risk for example children

If details can not obtained

Some callers can be reluctant to give details, lose consciousness or disconnect the call so it is not always possible to obtain the callers full details, in which case you can only work with the information you have**.** In this instance, look to see if the caller's number is displayed on the telephone screen. If the telephone number is available this can then be passed on to the emergency services and documented in the Affinity system incident report. If there is no number available, no details are obtained and the call is ended document the call and the steps taken to try to obtain the caller's details on the affinity system.

Getting help

In case of a physical emergency where police or ambulance need to be called always try to keep the caller on the line. Where possible get a colleagues attention by putting your hand up in the air and waving.

- **Once your colleague has seen this signal** they will sit beside you ready to make the emergency call while you keep the caller talking until emergency services arrive. Pass the details you have obtained on to your colleague on a piece of paper and they can then make the call on your behalf and take note of the emergency services incident/reference number.
- **If this is not possible** explain to the caller that the line will go quiet while you get help but to stay on the line. Put the caller on hold and ring the appropriate emergency service using the cordless telephone based within the helpline office. When you have ended the call to the emergency services, take the caller off hold and continue to talk to them until help arrives. Where possible try to speak to the emergency services when they arrive to ensure they are there and ready to take over. (N.B Any paper notes need to be shredded as soon as the incident has been recorded in Affinity).

5. Call Ended

Ensure call is recorded as a crisis call on the database and fill in an incident report on the affinity system including any police/ambulance reference numbers and names of people spoken to where appropriate. For guidance notes on how to log an incident on affinity on your computer;

1. Click Computer start icon at the bottom left corner of your computer screen
2. A menu will appear. Click ‘computer’
3. Click ‘J Drive’.
4. Click on the ‘Helpline’ folder.
5. Click ‘TSW Info’ folder.
6. Click ‘Telephone Procedures’.
7. Click ‘*Reporting an incident on Affinity system’.*

Appendix D

Crisis calls [Dementia]

A crisis call is when a caller to the helpline is describing a situation which presents an immediate or imminent threat to safety/ wellbeing. This is the case if the caller or the call handler feels the situation is unmanageable or unsafe and needs to be addressed urgently. Crisis situations would include;

► Carers calling reporting the current care arrangements for someone with dementia are no longer effective and the person with dementia is no longer safe as a result (this maybe due to a change in presentation or behaviour of the person with dementia.)

► Carers who are no longer able to provided care due to their physical or emotional wellbeing being compromised.

► Individuals with dementia reporting they are un safe or at risk themselves.

If a caller is in crisis they will be offered the appropriate numbers to access assistance according to their situation.

The options in this situation are; (if you need support in identifying the most appropriate team to support the caller contact the on call manager immediately).

To contact their GP. The GP can investigate any medical conditions that may be contributing to the situation (i.e. UTI) and refer on to other services.

Emergency services- if the caller or someone else is in danger which requires an immediate response (i.e. the person with dementia is threatening to hurt themselves or someone else).
999

All crisis calls will be recorded as such on the data collection form and should be discussed with a Contact Centre Manager or Team Leader once the immediate issue has been dealt with.

IF YOU RECEIVE A CRISIS CALL A CONTACT CENTRE MANAGER OR TEAM LEADER MUST BE INFORMED

Updated: 25/11/2013

Appendix E

mental health matters	Document Title	Helpline: Crisis Calls Procedure
	Issue No.	2
	Date of Issue	8th November 2007
	Date of Last Review	24th August 2011
	Date to be Reviewed	24th August 2013
	Meeting Corporate Objective	
	Authorised by	Helen MacKay

Related Documents

1. Crisis Call Flowchart
2. Risk Assessment Form

1. Purpose

1.1. The purpose of these guidelines is to ensure that calls which are identified as being Crisis or Emergency Calls are dealt with appropriately.

1.2. Helpline Workers have a structured process to follow when dealing with such situations.

2. Determining Crisis/Emergency Calls

2.1. Any call which meets the following criteria will be considered to be an emergency or crisis call:

2.1.1. Where the Helpline Worker, through use of Risk Assessment Form, identifies that at that moment in time a caller is in a situation where they could harm themselves or any other person(s).

2.1.2. Where the Helpline Worker, through the use of the Risk Assessment form, identifies that the caller is indicating suicidal intent.

2.1.3. Where it is apparent that the caller is experiencing extreme emotional distress e.g. crying, unable to verbalise feelings/experiences, unable to rationalise feelings/experiences.

2.1.4. Where it is apparent that a caller is experiencing acute symptoms of mental illness which are causing emotional distress and confusion, particularly psychosis e.g. hallucinations (audio/visual), sense of being unreal, delusional thoughts, paranoia physical distress e.g. side effects of medication, physical pain caused by illness/accident or where a caller has already self-harmed/attempted suicide.

3. Procedure

3.1. Listen to the caller, offer reassurance and gather information for completing risk assessment incident form.

3.2. It may be that even though caller is in crisis that she/he is not at risk of harm/abuse. The caller may require support and reassurance to overcome the present crisis situation.

3.3. Through completion of the risk assessment incident form it may become apparent that the caller is at risk from harm/abuse. It is then necessary to gather adequate information to contact an appropriate service to intervene.

3.4. Follow the Crisis Call Flow Chart.

4. Monitoring and Review of this Procedure

4.1. This procedure is part of Mental Health Matters quality standards. It will be reviewed at two yearly intervals and positive action will be taken to remedy any defects.